MEMBER SERVICES

1. Members Rights And Responsibilities

A. Member Rights and Responsibilities

Contractor shall develop, implement and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members and providers.

1. Contractor's written policy regarding Member rights shall include the Member's right:
   - to be treated with respect and in a confidential manner,
   - to be provided with information about the organization and its services,
   - to be able to choose a Primary Care Provider within the Contractor's network,
   - to participate in decision making regarding their own health care,
   - to voice Grievances about the organization or the care received,
   - to formulate advance directives,
   - to have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the Contractor's network pursuant to the federal law,
   - to request a state Medi-Cal fair hearing,
   - to have access to their Medical Record,
   - to disenroll upon request, and,
   - to access minor consent services.

2. Contractor's written policy regarding Member responsibilities shall include providing accurate information to the professional staff, following instructions, and cooperating with the providers.

B. Members' Right to Confidentiality

Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

1. Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.

2. Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22, CCR, Section 51009.

C. Members' Rights to Advance Directives

Contractor shall implement and maintain written policies and procedures respecting advance directives in accordance with the requirements of 42 CFR § 434.28.

2. Member Services Staff

A. Contractor shall maintain the capability to provide Member services to Medi-Cal Members through sufficient assigned and knowledgeable staff.

B. Contractor shall ensure Member services staff are trained on all contractually required Member service functions including, policies, procedures, and scope of benefits of this Contract.

3. Call Center Reports

Contractor shall report quarterly, in a format to be approved by DHS, the number of calls received by call type (questions, grievances, access to services, request for health education, etc.); the average speed to answer Member services telephone calls with a live voice; and, the Member services telephone calls abandonment rate.

4. Written Member Information

A. Contractor shall provide all new Medi-Cal Members with written Member information as specified in Title 22, CCR, Section 53895. Compliance with items required by Section 53895(b) may be met through distribution of the Member Services Guide.

The Member Services Guide shall meet the requirements of an Evidence of Coverage and Disclosure Form (EOC/DF) as stipulated by Title 28, CCR, Sections 1300.51(d), Exhibit T (EOC) or U (Combined EOC/DF) and Title 22, CCR, Section 53881. In addition, the Member Services Guide shall meet the requirements contained in Health and Safety Code, Section 1361.1, and Title 28, CCR, Section 1300.63(a), as to print size, readability, and understandability of text.

B. Contractor shall distribute the Member information no later than seven (7) days after the effective date of the Member's Enrollment. Contractor shall revise this information, if necessary, and distribute it annually to each Member or family unit.

C. Contractor shall ensure that all written Member information is provided to Members at a 5th grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by DHS. The written Member information shall ensure Members' understanding of the health plan processes and to ensure the Member's ability to make informed health decisions.

Written material shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, provision 13, regarding Linguistic Services.

Upon request from a visually impaired Member, written Member materials in either Braille or a format utilizing a size fourteen (14) type font shall be provided.

D. Contractor shall develop and provide each Member, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of the covered health care services. The Member Services Guide shall be submitted to DHS for review prior to distribution to Members. The Member Services Guide shall include the following information:

1. The plan name, address, telephone number and service area covered by the health plan.

2. A description of the full scope of Medi-Cal Managed Care covered benefits and all available services including health education, interpretive services provided by plan personnel and at service sites, and "carve out" services and an explanation of any service limitations and exclusions from coverage or charges for services. Include information and identification of services to which the Contractor or subcontractor has a moral objection to perform or support.

3. Procedures for accessing Covered Services including that Covered Services shall be obtained through the plan's providers unless otherwise allowed under this Contract.

   A description of the Member identification card issued by the Contractor, if applicable, and an explanation as to its use in authorizing or assisting Members to obtain services.

4. Compliance with the following may be met through distribution of a provider directory:

   The address and telephone number of each Service Site (e.g., locations of hospitals, Primary Care Physicians (PCP), optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities, FQHCs, Indian Health Centers). In the case of a medical group/foundation or independent practice association (IPA), the medical group/foundation or IPA name, address and telephone number shall appear for each Physician provider:

   The hours and days when each of these Facilities is open, the services and benefits available, and the telephone number to call after normal business hours.

5. Procedures for selecting or requesting a change in PCP at any time; any requirements that a Member would have to change PCP; reasons for which a request for a specific PCP may be denied; and reasons why a provider may request a change.

6. The purpose and value of scheduling an initial health assessment appointment.

7. The appropriate use of health care services in a managed care system.

8. The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate provider locations and telephone numbers.

9. Procedures for obtaining emergency health care from specified plan providers or from non-plan providers, including outside Contractor's Service Area.

10. Process for referral to specialists.

11. Procedures for obtaining any transportation services to Service Sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of both medical and non-medical transportation services and the conditions under which non-medical transportation is available.

12. Procedures for filing a grievance, including procedures for appealing decisions regarding Member's coverage, benefits, or relationship to the organization. Include the title, address, and telephone number of the person responsible for processing and resolving grievances.

13. The causes for which a Member shall lose entitlement to receive services under this Contract as stipulated in Exhibit A, Attachment 16, provision 3. Disenrollment.

14. Procedures for Disenrollment, including an explanation of the Member's right to disenroll without cause at any time, subject to any restricted disenrollment period.

15. Information on the Member's right to the Medi-Cal fair hearing process regardless of whether or not a grievance has been submitted or if the grievance has been resolved, pursuant to Title 22, CCR, Section 53452, when a health care service requested by the Member or provider has been denied, deferred or modified. The State Department of Social Services' Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253).

16. Information on the availability of, and procedures for obtaining, services at FQHCs and Indian Health Clinics.

17. Information on the Member's right to seek family planning services from any qualified provider of family planning services under the Medi-Cal program, including providers outside Contractor's provider network, how to access these services, and a description of the limitations on the services that Members may seek outside the plan. Contractor may use the following statement:

    Family planning services are provided to Members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name (Contractor)] without having to get permission from [Plan Name (Contractor)]. [Plan Name (Contractor)] shall pay that doctor or clinic for the family planning services you get.

18. DHS' Office of Family Planning toll-free telephone number (1-800-942-1054) providing consultation and referral to family planning clinics.

19. Information on the availability of, and procedures for obtaining, Certified Nurse Midwife and Certified Nurse Practitioner services, pursuant to Exhibit A, Attachment 9, provision 7, on Nurse Midwife and Nurse Practitioner Services.

20. Information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Contractor shall include this information with all Member Service Guides sent to Members after the date such information is furnished to Contractor by DHS.

21. Information on how to access State resources for investigation and resolution of Member complaints, including a description of the DHS Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609), and the Department of Managed Health Care, Health Maintenance Organization (HMO) Consumer Service toll-free telephone number (1-800-400-0815).

22. Information concerning the provision and availability of services covered under the CCS program from providers outside Contractor's provider network and how to access these services.

23. An explanation of the expedited Disenrollment process for Members qualifying under conditions specified under Title 22, CCR, Section 53889(j) which includes children receiving services under the Foster Care or Adoption Assistance Programs; Members with special health care needs, including, but not limited to major organ transplants; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.

24. Information on how to obtain Minor Consent Services through Contractor's provider network, an explanation of those services, and information on how they can also be obtained out of the Contractor’s provider network.

25. An explanation on how to use the Fee-For-Service system when Medi-Cal covered services are excluded or limited under this Contract and how to obtain additional information.

26. An explanation of an American Indian Member's right to not enroll in a Medi-Cal Managed Care plan, to be able to access Indian Health Service facilities, and to disenroll from Contractor's plan at any time, without cause.

27. A notice regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor. Pursuant to California Health and Safety Code, Section 7158.2, this notice must be provided upon enrollment and annually thereafter in the evidence of coverage (Member Services Guide), health plan newsletter or any other direct communication with Members.

28. A statement as to whether the Contractor uses provider financial bonuses or other incentives with its contracting providers of health care services

and that the Member may request additional information about these bonuses or incentives from the plan, the Member's provider or the provider's medical group or independent practice association, pursuant to California Health and Safety Code, Section 1367.10.

29. A notice as to whether the Contractor uses a drug formulary. Pursuant to California Health and Safety Code, Section 1363.01, the notice shall: (1) be in the language that is easily understood and in a format that is easy to understand; (2) include an explanation of what a formulary is, how the plan decides which prescription drugs are included in or excluded from the formulary, and how often the formulary is updated; (3) indicate that the Member can request information regarding whether a specific drug is on the formulary and the telephone number for requesting this information; and (4) indicate that the presence of a drug on the plan's formulary does not guarantee that a Member will be prescribed that drug by his or her prescribing provider for a particular medical condition.

30. Policies and procedures regarding a Members' right to formulate advance directives.

31. Any other information determined by DHS to be essential for the proper receipt of Covered Services.

E. Member Identification Card

Contractor shall provide an identification card to each Member, which identifies the Member and authorizes the provision of Covered Services to the Member. The card shall specify that Emergency Services rendered to the Member by non-Contracting providers are reimbursable by the Contractor without Prior Authorization.

5. Notification of Changes in Availability or Location of Covered Services

Contractor shall ensure Medi-Cal Members are notified in writing of any changes in the availability or location of Covered Services at least thirty (30) days prior to the effective date of such changes. In cases of unforeseeable circumstances, notice shall be given within fourteen (14) days prior to the change unless DHS determines that post-change notification is appropriate. In this latter instance, notice to Members shall be provided within fourteen (14) days subsequent to the change. The notification must also be presented to and approved in writing by DHS prior to its' release.

6. Primary Care Provider Selection

A. Contractor shall implement and maintain DHS approved procedures to ensure that each new Member has an appropriate and available Primary Care Physician. Contractor shall provide each new Member an opportunity to select a Primary Care Physician within the first thirty (30) days of enrollment. If the Contractor's provider network includes nurse practitioners, certified nurse midwives, or physician assistants, the Member may select a nurse practitioner, certified nurse midwife, or physician assistant within thirty (30) days of enrollment to provide Primary Care services in accordance with Title 22, CCR, Section 53853(a)(4). Contractor shall ensure that Members are allowed to change a Primary Care Physician, nurse practitioner, certified nurse midwife or physician assistant, upon

request, by selecting a different Primary Care Provider from Contractor's network of providers.

B. Contractor shall disclose to affected Members any reasons for which their selection or change in Primary Care Physician could not be made.

C. Contractor shall ensure that Members with an established relationship with a provider in Contractor's network, who have expressed a desire to continue their patient/provider relationship, are assigned to that provider without disruption in their care.

D. Contractor shall ensure that Members may choose traditional and safety net providers as their Primary Care Provider.

7. Primary Care Provider Assignment

A. If the Member does not select a Primary Care Provider within thirty (30) days of the effective date of enrollment, Contractor shall assign that Member to a Primary Care Provider and notify the Member and the assigned Primary Care Provider no later than forty (40) days after the Member's Enrollment. Contractor shall ensure that adverse selection does not occur during the assignment process of Members to providers.

B. Contractor shall notify the Primary Care Provider that a Member has selected or been assigned to the provider within seven (7) days from when selection or assignment is completed by the Member or the Contractor, respectively.

C. Contractor shall maintain procedures that proportionately include contracting traditional and safety-net providers in the assignment process for Members who do not choose a Primary Care Provider.

8. Denial, Deferral, or Modification of Prior Authorization Requests

A. Contractor shall notify Members of denial, deferral, or modification of requests for Prior Authorization, in accordance with Title 22, CCR, Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in Title 22, CCR, Sections 51014.1, 51014.2, and 53894.

B. Contractor shall provide for a written notification to the Member and the Member's representative on a standardized form informing the Member of all the following:

1. The Member's right to, and method of obtaining, a fair hearing to contest the denial, deferral or modification action.

2. The Member's right to represent himself/herself at the fair hearing or to be represented by legal counsel, friend or other spokesperson.

3. The name and address of Contractor and the State toll-free telephone number for obtaining information on legal service organizations for representation.

4. That the Member may file a Grievance concerning Contractor's action using Contractor's Grievance process prior to or concurrent with the initiation of the fair hearing process.

C. Contractor shall provide required notification to beneficiaries and their authorized representatives in accordance with the time frames set forth in Title 22, CCR, Sections 51014.1 and 53894.